APPLICATION FOR STUDENT PERMIT TO PRACTICE RESPIRATORY CARE

State Form 50819 (2-02)
Approved by State Board of Accounts, 2002

HEALTH PROFESSIONS BUREAU
402 West Washington Street, Room 041
Indianapolis, IN 46204
(317) 234-2054
www.IN.gov/hpb

APPLICATION FEE	
DATE FEE PAID	
RECEIPT NUMBER	
STUDENT PERMIT NUMBER	
STUDENT PERMIT ISSUE DATE	

APPLICANT
Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

*** Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

PART I. APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number *
Address (*number and street or rural route*)		
City	State	ZIP code
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Telephone number (*daytime*)	Email address	

SCHOOL OR PROGRAM OF RESPIRATORY CARE CURRENTLY ENROLLED

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE ENTERED	DATE OF EXPECTED GRADUATION

OTHER SCHOOLS OR PROGRAMS ATTENDED

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED	DEGREE GRANTED

Do you hold or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☐ **Yes** ☐ **No**
(*If yes, please explain in the space located below.*)

LIST ALL PLACES YOU HAVE LIVED SINCE ENROLLING IN YOUR SCHOOL OR PROGRAM

GENERAL LOCATION	DATES

LIST ALL PLACES WHERE YOU HAVE BEEN EMPLOYED TO PRACTICE RESPIRATORY CARE PRIOR TO APPLYING FOR A STUDENT PERMIT		
EMPLOYER	**ADDRESS**	**DATES OF EMPLOYMENT**

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. Letters from attorneys are not accepted in lieu of your statement. Falsification of any of the following, is grounds for permanent revocation of a permit issued pursuant to this application.	
1. Have you ever previously filed an application in the State of Indiana?	☐ Yes ☐ No
2. Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
3. Have you ever been denied a license, certificate, registration or permit to practice respiratory care or any regulated health occupation in any state (*including Indiana*) or country?	☐ Yes ☐ No
4. Are you now being, or have you ever been treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or nolo contendere to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor traffic laws resulting in fines.*)	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION	
I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of their authorized representatives in connection with processing my application for a student permit to practice repertory care. I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information. A photostatic copy of this authorization has the same force and effect as the original.	
I hereby swear or affirm, that I have read the above statements and agree to same.	
Signature of applicant	Date signed (*month, day, year*)

PART II.
APPLICATION FOR A STUDENT PERMIT TO PRACTICE RESPIRATORY CARE
HOSPITAL OR FACILITY OF EMPLOYMENT
(*This form is to be completed by the hospital or facility where the applicant will be employed*.)

NAME OF STUDENT	
Name of student	Social Security number *

NAME OF LICENSED RESPIRATORY CARE PRACTITIONER SUPERVISOR DESIGNEE	
Name of RCP supervisor designee	
Respiratory care license number	Expiration date
Telephone number	Email address

HOSPITAL OR FACILITY OF EMPLOYMENT		
Name of hospital or facility		
Address (*number and street or rural route*)		
City	State	ZIP code

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of Licensed Respiratory Care Practitioner	Date signed (*month, day, year*)

SUPERVISION OF STUDENT PERMIT HOLDER

ACCORDING TO IC 25-34.5-2-14(f) & (g):

(f) A holder of a student permit shall meet in person at least one (1) time each working day with the permit holder's supervising practitioner or a designated respiratory care practitioner to review the permit holder's clinical activities. The supervising practitioner or a designated respiratory care practitioner shall review and countersign the entries that the permit holder makes in a patient's medical record not more than seven (7) calendar days after the permit holder makes the entries.

(g) A supervising practitioner may not supervise at one (1) time more than three (3) holders of student permits issued under this section.

IF THE STUDENT PERMIT HOLDER LEAVES YOUR EMPLOYMENT YOU MUST NOTIFY THE RESPIRATORY CARE COMMITTEE.

PART III.
APPLICATION FOR A STUDENT PERMIT TO PRACTICE RESPIRATORY
SCHOOL OR PROGRAM OF RESPIRATORY CARE
PROCEDURES COMPLETED BY THE STUDENT PERMIT HOLDER
(*To be completed by the Program Director and Director of Clinical Education of the Respiratory Care School or Program*)

APPLICANT INFORMATION	
Name of student	Social Security number *

SCHOOL OR PROGRAM OF RESPIRATORY CARE		
Name of school or program		
Date of admission	Date of expected graduation	
Address (*number and street or rural route*)		
City	State	ZIP code
Name of program director		
Telephone number	Email address	
Name of program director of clinical education		
Telephone number	Email address	

AFFIRMATION	
I hereby swear or affirm that the applicant is a student in good standing in a program or school of respiratory care which is approved by the Indiana Respiratory Care Committee and the applicant has successfully completed the list of procedures which is attached to this application.	
Signature of program director	Date signed (*month, day, year*)
Signature of program director of clinical education	Date signed (*month, day, year*)

The program director or director of clinical education must notify the Indiana Respiratory Care Committee if the student ceases to be in good standing in the respiratory care program. Failure to do so may be grounds for disciplinary action.

RESPIRATORY CARE PROCEDURES

Please check-off the procedures which have been a part of a course that the applicant has successfully completed in the respiratory care program and completion has been documented in both lecture and lab, and also in clinical.

Please note that the procedures permitted may be performed only:
(1) on adult patients who are not critical care patients; and
(2) under the proximate supervision of a licensed respiratory care practitioner.

PROCEDURES	CHECK-OFF
1. Aerosol Medication Delivery	☐ Completed
2. Airway Clearance Techniques	☐ Completed
3. Capnography	☐ Completed
4. Chest Physiotherapy	☐ Completed
5. Completion of Basic Respiratory Pharmacology	☐ Completed
6. Cylinders	☐ Completed
7. Directed Cough Technique	☐ Completed
8. EKG	☐ Completed
9. Endotracheal Suctioning	☐ Completed
10. Flow Meters	☐ Completed
11. Gas Regulators	☐ Completed
12. Humidity and Aerosol Therapy	☐ Completed
13. Incentive Spirometry	☐ Completed
14. Intermittent Positive - Pressure Breathing Therapy	☐ Completed
15. Liquid Systems	☐ Completed
16. Manual Ventilation	☐ Completed
17. Medical Records	☐ Completed
18. Metered Dose Inhaler	☐ Completed
19. Minute Ventilation	☐ Completed
20. Nasotracheal Suctioning	☐ Completed
21. Oxygen Analysis	☐ Completed
22. Oxygen Therapy	☐ Completed
23. Oxygen / Medical Gas Administration	☐ Completed
24. Patient Interview and History	☐ Completed
25. Peak Flow	☐ Completed
26. Pharyngeal Airway Insertion	☐ Completed
27. Physical Assessment of Chest	☐ Completed
28. Spirometry Screening	☐ Completed
29. Sputum Inductions	☐ Completed
30. Tidal Volume	☐ Completed
31. Tracheostomy Care	☐ Completed
32. Transutaneous Monitors	☐ Completed
33. Universal Precautions	☐ Completed
34. Vital Capacity	☐ Completed
35. Vital Signs	☐ Completed